Tennessee
Health Care Innovation Initiative

Provider Stakeholder Group Meeting

May 21, 2014

Agenda

Update on the episodes of care reporting

Payment and delivery reform for LTSS

Update on the episodes of care reporting

- Last week, we announced a significant milestone in the Tennessee Health Care Innovation Initiative: Principal Accountable Providers began receiving their first "information only" episodes of care cost and quality reports.
- Provider reports were released from the three TennCare MCOs (Amerigroup, BlueCare, and UnitedHealthcare Community Plan).
  - Blue Cross Blue Shield of Tennessee commercial networks also released reports for fully insured and state employee members, TennCareSelect, and CoverKids.
  - Provider will begin receiving reports for UnitedHealthcare's commercial network for fully-insured members later this summer, and Cigna will be reaching out to targeted providers within its network on an ongoing basis.
- In total over **1,700** reports we released last week to over **500** unique providers.
- The best way for quarterbacks to discuss the specifics of their own episodes is to talk to the insurance companies that are implementing episodes of care. Below are the appropriate contact numbers for providers to use:
  - Amerigroup – 615-316-2460
  - Blue Cross Blue Shield of Tennessee – 1-800-924-7141, Option 4
  - Cigna – 615-595-3756
  - UnitedHealthcare – 615-372-3509

Agenda

Update on the episodes of care reporting

Payment and delivery reform for LTSS

TennCare
Health Care Innovation:

Long-Term Services and Supports (LTSS) Value-Based Purchasing Initiatives

May 21, 2014

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Value-Based Purchasing Initiatives

- Quality Improvement in Long-Term Services and Supports (QuILTSS)
- Enhanced Respiratory Care Initiative

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QuILTSS

- A TennCare value-based purchasing initiative to promote the delivery of high quality LTSS
- Focus on performance measures that are most important to people who receive LTSS and their families—that most directly impact the member's experience of care
- Creation of a new TennCare LTSS payment system (aligning payment with value/quality) for NFs and certain "core" HCBS based in part on performance on specified measures
- Robert Wood Johnson Foundation State Quality and Value Strategies grant
- Lipscomb University contracted by Princeton University to provide technical assistance and facilitate QuILTSS stakeholder processes

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QuILTSS

Process Included:

- Survey of Federal & State Landscape
- Literature Review
- Key Informant Interviews with Other States
- Stakeholder Input Processes
- Data Analysis
- Report and recommendations on Process and Quality Measure Domains

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QuILTSS

Stakeholder Input Process Included:

- Community Forums
  - 18 sessions between October 24-November 4
  - Over 1,200 participants
    - 290 Consumers
    - 831 Providers (388 NF and 443 HCBS)
- Online Survey
- One-on-One Meetings with Key Stakeholders

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QuILTSS

Data Analysis:

- 1,755 Different Idea Responses
  Consumers 463 ideas
  Providers 1,155 ideas
  MCOs 137 ideas

- Sorted into seven overarching categories
  Six with subcategories

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TABLE 1

Categories and Indicators of Quality from Community Forums		
Building/Grounds (BG) ◆ Clean ◆ Safe ◆ Home ◆ Privacy ◆ Affordable ◆ Finance	**Clinical (C)** ◆ Medicines ◆ Falls ◆ Wound/sore ◆ Emergency room (utilization) ◆ Infection ◆ Transition ◆ Improve outcomes ◆ Antipsychotic medication (use) ◆ Pain ◆ Restraint	**Health/Wellness (HW)** ◆ Needed care ◆ Nutrition ◆ Preventative ◆ Chronic ◆ Active ◆ Mental health ◆ Activities of Daily Living ◆ Weight
Meaningful Day (MD) ◆ Life ◆ Transportation ◆ Activities ◆ Religious (access to) ◆ Social Independence	**Person-Centered Care (PCC)** ◆ Choice ◆ Hygiene ◆ Individual ◆ Communication ◆ Consumer satisfaction ◆ Family	**Workforce (W)** ◆ Dignity/caring ◆ Trained ◆ Consistent/stable ◆ Employee retention/satisfaction ◆ Reliable ◆ Coordination ◆ Responsive ◆ Compatibility ◆ Flexibility ◆ Ethical/professional ◆ Abuse ◆ Supervision
Discharge to Home (No indicators)		

QuILTSS

Results:

- Process Recommendations
- Domain Recommendations
- Comprehensive report available at: www.lipscomb.edu/transformaging/TAReport

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Current NF Reimbursement

- **Prospective:** Payment of rates based on historical data or budget projections with no subsequent settlement to actual costs
- **Cost-based:** A provider-specific rate determined by using the provider's own cost experience or budget projections
- Facilities submit an annual cost report to the Comptroller's Office—for Level 1 and Level 2 NF Reimbursement
- Each facility's costs are calculated based on:
  - Operating costs
    - --Direct
    - --Indirect
  - Capital costs

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Current NF Reimbursement

- Per diem rate established for each facility based on allowable costs
- Each NF's cost report inflated from mid-point of cost reporting period to mid-point of pmt period
  - For NFs in Medicaid program at least 3 years, trending factor is average cost increase over the 3-year period, limited to the 75th percentile trending factor of all NFs participating for at least 3 years
  - For NFs in Medicaid program < 3 years, trending factor is 50th percentile trending factor of NFs in Medicaid program for at least 3 years
- Rates capped at the 65th percentile of all facilities receiving the applicable level of reimbursement (Level 1 or 2)

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New NF Reimbursement Methodology

SB 1872 HB 1783

- Developed by THCA on behalf of the NF industry
- Passed by the General Assembly – Public Chapter 859
- Effective July 1, 2014
- Converts current bed tax to an assessment fee —similar to the hospital fee (contingent upon CMS approval)
- NF assessment - 4.5% of net patient service revenue based on a per-resident day basis, excluding Medicare resident days

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New NF Reimbursement Methodology

SB 1872 HB 1783

- Will be used to draw down additional federal $ for the sole purpose of providing payments to NFs in order to:
  - Offset 1% reduction for NF services in the FY 2015 budget
  - Provide a supplemental transition (or "bridge") payment pending transition to an acuity based reimbursement system—30% based on the 2013 supplemental acuity payment methodology; 30% based on a slightly different case mix adjustment approach (Medicaid day-weighted case mix index score); and 20% based on quality measures; 19% for restoration of 1% reduction and 1% for administrative costs associated with systems development for electronic submission of cost reports and data
  - Provide funding for the implementation of the acuity-based system which shall include a quality performance component and a nursing rate component (Nursing rate component will be case-mix adjusted using RUGs)

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New NF Reimbursement Methodology

SB 1872 HB 1783

- Has the potential to accomplish several things:
  - "Modernize" the bed tax and reimbursement approach
  - Allow TennCare to increase NF reimbursement based on the higher acuity of people receiving NF services
  - Allow TennCare to target significant new resources to improve the quality of NF services members receive—the member's experience of care, using measures identified in QuILTSS

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QuILTSS

Next Steps:

- Semi-monthly meetings with Stakeholders
  - Finalize NF measures by 6/30
  - Continue working to finalize HCBS measures
  - Finalize transition payment and new NF reimbursement methodologies, including quality components
  - Establish implementation plan/timeline, including TennCare rule revisions, provider training, etc.

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Value-Based Purchasing for Enhanced Respiratory Care

- Ventilator program established in Tennessee in 2002
  - Need for placement of high acuity, respiratory, tracheostomized and ventilator dependent patients
  - 60 patients (deemed un-weanable) liberated from mechanical ventilation in the first year and discharged
- Standards of care developed and implemented; ultimately became part of the nationally recommended standards from the American Association for Respiratory Care
- Regional units opened (3 statewide), with liberation rates in the 65% range
  - Total of 48 beds in 2010

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Value-Based Purchasing for Enhanced Respiratory Care

- 2010
  - Medicare revised RUG rates for ventilator care from average of $350 per day to $700 per day
  - TennCare implemented Enhanced Respiratory Care rates
    - Ventilator Weaning - $750 per day
    - Chronic Ventilator Care - $600 per day
    - Tracheal Suctioning - $400 per day
- Expansion of program to 9 units, 222 beds as of 2013, with additional expansion in process
- Significant growth in expenditures since 2010, primarily chronic ventilator care (little focus on liberation)
- Little tracking of quality metrics or consistency
- Large number of out-of-state admissions (70 in 2013)

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Value-Based Purchasing for Enhanced Respiratory Care

- Evaluate current status and practices
- Develop key performance indicators
  - Structure and process of care measures
  - Clinical outcome measures
  - Develop value-based purchasing approach, including implementation plan/timeline
    - Align incentives to encourage use of more effective less costly noninvasive technology
    - Develop methods and incentives to maximize the patient's independence and quality of life
- Develop and implement comprehensive Utilization Management approach
- Develop and implement ongoing Quality Improvement approach

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Value-Based Purchasing for Enhanced Respiratory Care

***Potential* P4P quality measures:**

- Annual Wean Rates (% of admissions weaned within 12 months)
- Length of stay to Wean (average days from admission to wean)
- Infection Rates (% of admissions that acquire respiratory infections within 4 days of admission)
- Hospital Re-Admission Frequency
- Decannulation Rate

***Potential* P4P technology measures (encourage best practices):**

- Humidification
- Use of Non-Invasive Technology

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Value-Based Purchasing for Enhanced Respiratory Care

Potential additional **quality metrics (threshold reporting requirement):**

- Census by type (i.e., level of reimbursement)
- Number of referrals and admissions
- Number of out-of-state referrals and admissions
- Number of admissions by pay source
- Number of admissions by diagnoses and type (i.e., level of reimbursement)
- Number liberated from vent
- Number decannulated
- Number discharged from ERC and where
- Number transferred to hospital and returned
- Number transferred to hospital and not returned
- Unanticipated death in facility
- 30 day and 60 day wean rates
- Number of patients in respiratory isolation

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Value-Based Purchasing for Enhanced Respiratory Care

Next Steps:

- Finalize proposed quality measures and proposed P4P approach
- Meet with stakeholders to provide opportunity for input
- Finalize quality measures and P4P approach
- Develop implementation plan/timeline, including TennCare rule revisions, provider training, etc.

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Integration and Coordination of Care for Dual Eligible Members

Dual Eligible Integration/Coordination

- Leverage Medicare Part C authority (D-SNP model) and member education to help align dual eligible members' enrollment in the same health plan for Medicare and Medicaid
- Duals receive Medicare benefits from the same MCO that provides their Medicaid services, although contracting arrangements remain separate
- Implement passive enrollment, where possible

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Dual Eligible Integration/Coordination

- Strengthen coordination requirements for TennCare MCOs and D-SNPs using MCO Contractor Risk Agreement and MIPPA (TennCare/D-SNP) Agreements
  - Focus on discharge planning, care transitions, use of LTSS
  - Full data interface (eligibility/enrollment and encounters)
- Continue to develop MCO and D-SNP requirements and State monitoring processes for D-SNPs to improve coordination over time

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Dual Eligible Integration/Coordination

- Develop new evaluation strategies to compare quality and cost-effectiveness of care to dual eligible members enrolled in original Medicare, Medicare Advantage, and coordinated or aligned D-SNP arrangements
- Help shape federal policy that will support better integration and coordination of care under Medicare Part C, including:
  - Reauthorization of D-SNPs that offer integrated Medicaid and Medicare benefits including behavioral health and/or LTSS
  - More flexible enrollment options into coordinated D-SNP arrangements
  - A better defined role for State Medicaid Agencies in the administration of D-SNPs
  - Alignment of administrative requirements across Medicare and Medicaid programs

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Home and Community Based Services (HCBS) Waiver Renewal/Redesign

HCBS Waiver Renewal/Redesign

3 Section 1915(c) HCBS Waiver Programs for individuals with intellectual disabilities:

- **Arlington** Waiver Program (**296** participants as of March 2014)
- **Statewide** Waiver Program (**6,356** participants)
- **Self-Determination** Waiver Program (**1,122** participants)

Arlington and Statewide waivers must be renewed by **December 31, 2014**

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2011 Expenditures for TN 1915(c) Waivers for Individuals with Intellectual Disabilities

(based on CMS 372 Reports)

- **Arlington Waiver-** 341 unduplicated participants (unique individuals served across the program year); $48.5 million total waiver expenditures; average per person cost: **$142,031**
- **Statewide Waiver-** 6,336 unduplicated participants $520 million total waiver expenditures; average per person cost: **$82,220**
- **Self-Determination Waiver-** 1,227 unduplicated participants; $21.2 million total waiver expenditures; average per person cost: **$17,248**

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2011 Expenditures for TN 1915(c) Waivers for Individuals with Intellectual Disabilities

- The average cost of providing HCBS to individuals with ID in TN was significantly higher than most other states in 2011 – nearly twice the national average and nearly twice the median income of a family of four in TN

- Contributing factors include:
  - Developmental Center litigation
  - Waiting list selection criteria
    (people "in crisis" tend to need more intensive services)
  - Waiver program design

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*2011 Expenditures for TN 1915(c) Waivers for Individuals with Intellectual Disabilities Across States**

- Tennessee spent 162% of the median value of state spending on residential services (8th highest in the country among states that offer residential services).
- Tennessee spent 236% of the median value of state spending on personal assistance services (5th highest in the country among states that offer personal assistance).
- Tennessee spent 489% of the median value of state spending on nursing services (5th highest in the country among states that offer nursing services under these waivers).

* Based on an analysis of 2011 CMS 372 report data across all states

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Per Person DIDD Expenditures by State and Category

** "DIDD Expenditures" refers to spending by the Tennessee Department of Intellectual and Developmental Disabilities (DIDD).*

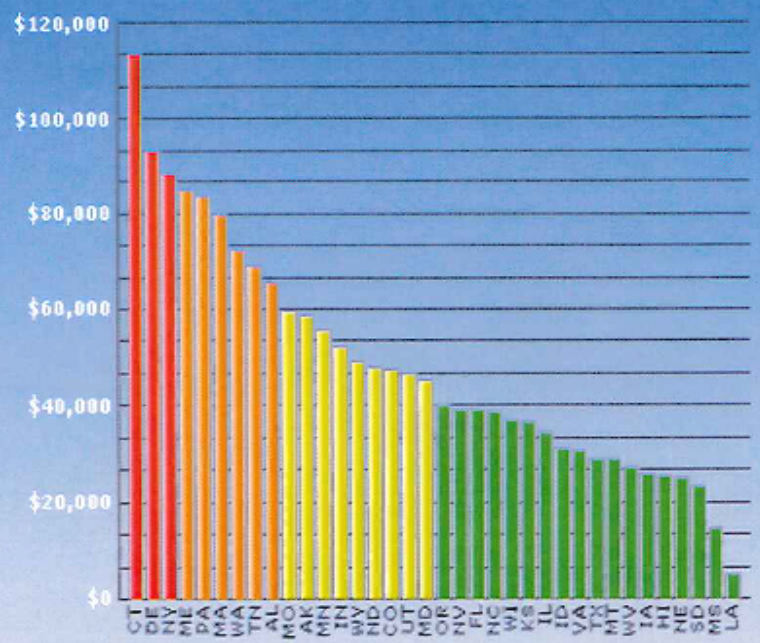
Personal Care
Residential Services
Respite Care

#8 Highest Expenditure on Residential Services

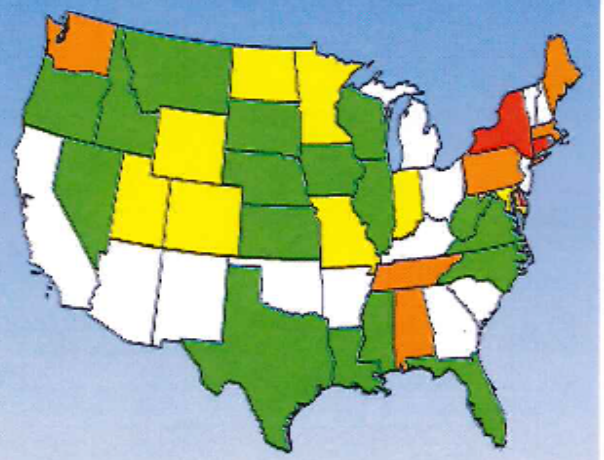
Out of 36 states

Per Person Expenditures on DIDD Services

Residential Services



Tennessee's per person expenditure of $69,077.72 is 162% of the median value of $42,663.42 for states that offer this service.



*** "All Services" includes only service categories that are common to TN.*

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Per Person DIDD Expenditures by State and Category

* "DIDD Expenditures" refers to spending by the Tennessee Department of Intellectual and Developmental Disabilities (DIDD).

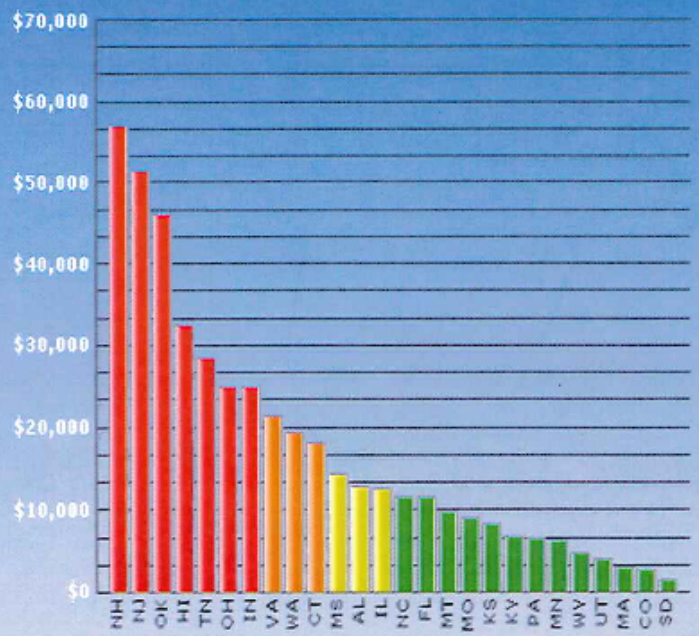
Nursing
Personal Care
Residential Services

#5 Highest Expenditure on Personal Care

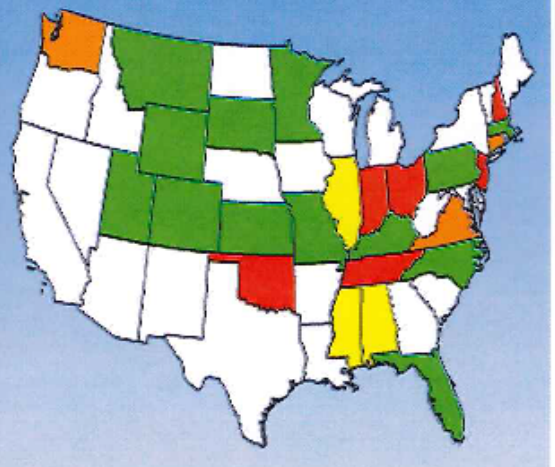
Out of 26 states

Per Person Expenditures on DIDD Services

Personal Care



Tennessee's per person expenditure of $28,304.62 is 236% of the median value of $11,988.57 for states that offer this service.



** "All Services" includes only service categories that are common to TN.

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Per Person DIDD Expenditures by State and Category

* "DIDD Expenditures" refers to spending by the Tennessee Department of Intellectual and Developmental Disabilities (DIDD).

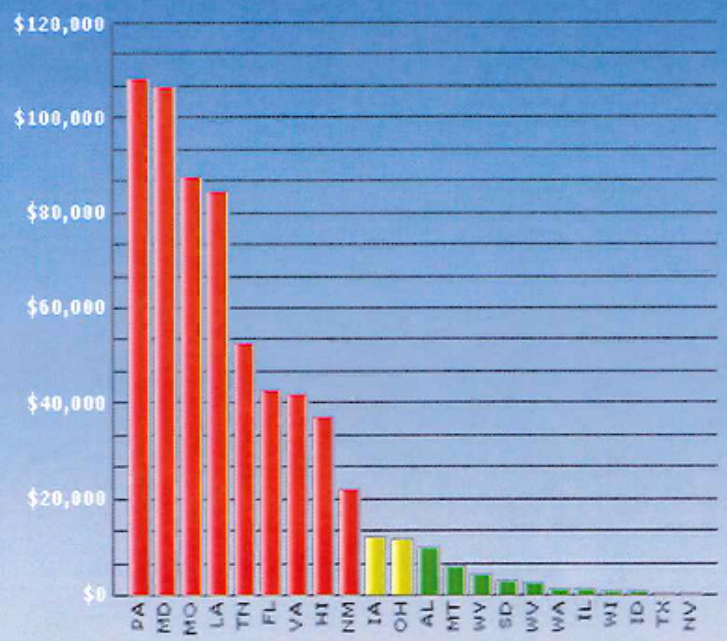
Nursing
Personal Care
Residential Services

#5 Highest Expenditure on Nursing

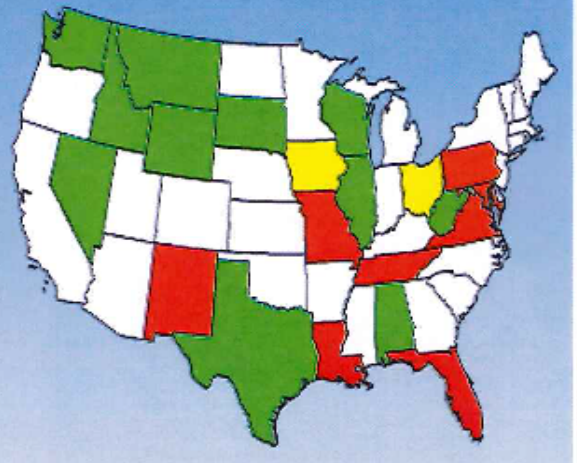
Out of 22 states

Per Person Expenditures on DIDD Services

Nursing



Tennessee's per person expenditure of $52,406.39 is 489% of the median value of $10,710.41 for states that offer this service.



** "All Services" includes only service categories that are common to TN.

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*2011 Expenditures for TN 1915(c) Waivers for Individuals with Intellectual Disabilities Compared to States in the Southeastern Region (CMS Region 4)**

- Tennessee spent 176% of the median value of state spending on residential services.
- Tennessee spent 234% of the median value of state spending on personal assistant services.
- Tennessee spent 123% of the median value of state spending on nursing services, and is one of only three states that offer nursing as a separate service under these waivers.

Tennessee had the highest expenditure of any state in the southeastern region for each of these services.

*Based on an analysis of 2011 CMS 372 report data across states in CMS Region 4

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Per Person DIDD Expenditures by CMS Region 4 State and Category

** "DIDD Expenditures" refers to spending by the Tennessee Department of Intellectual and Developmental Disabilities (DIDD).*

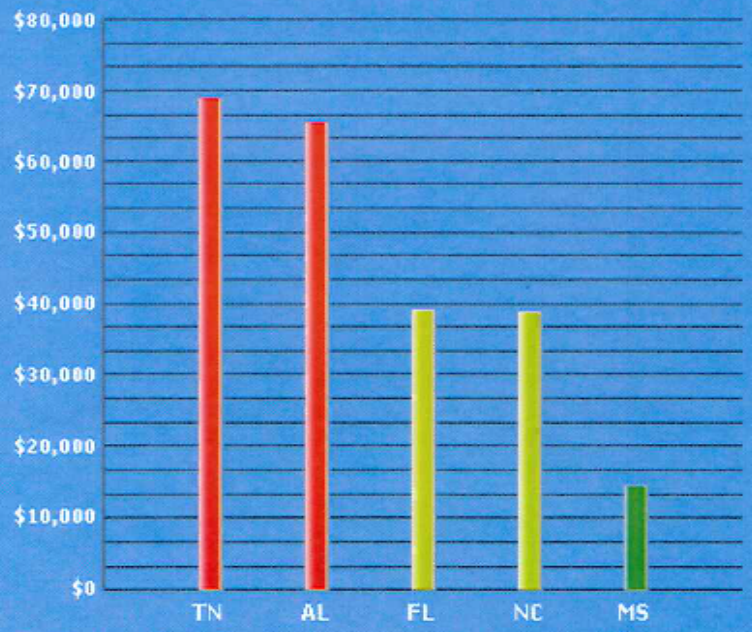
Nursing
Personal Care
Residential Services

#1 Highest Expenditure on Residential Services

Out of 5 states in CMS Region 4

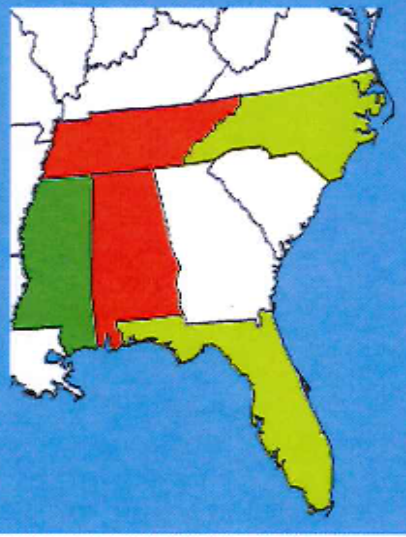
Per Person Expenditures on DIDD Services

Residential Services



*** "All Services" includes only service categories that are common to TN.*

Tennessee's per person expenditure of $69,077.72 is 176% of the median value of $39,309.36 for states that offer this service.



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TennCare

Per Person DIDD Expenditures by CMS Region 4 State and Category

** "DIDD Expenditures" refers to spending by the Tennessee Department of Intellectual and Developmental Disabilities (DIDD).*

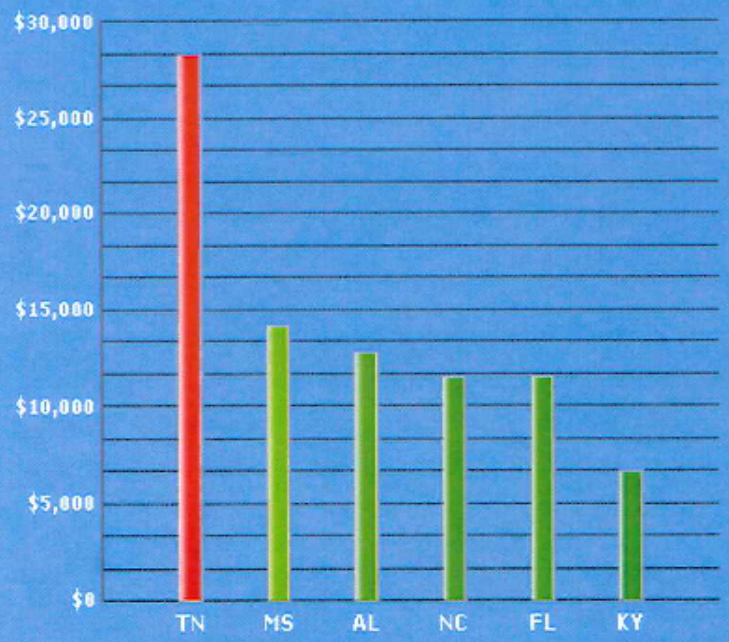
- Nursing
- Personal Care
- Residential Services

#1 Highest Expenditure on Personal Care

Out of 6 states in CMS Region 4

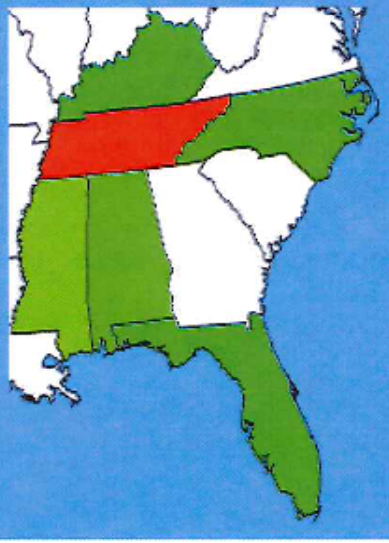
Per Person Expenditures on DIDD Services

Personal Care



*** "All Services" includes only service categories that are common to TN.*

Tennessee's per person expenditure of $28,304.62 is 234% of the median value of $12,118.13 for states that offer this service.



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Per Person DIDD Expenditures by CMS Region 4 State and Category

* "DIDD Expenditures" refers to spending by the Tennessee Department of Intellectual and Developmental Disabilities (DIDD).

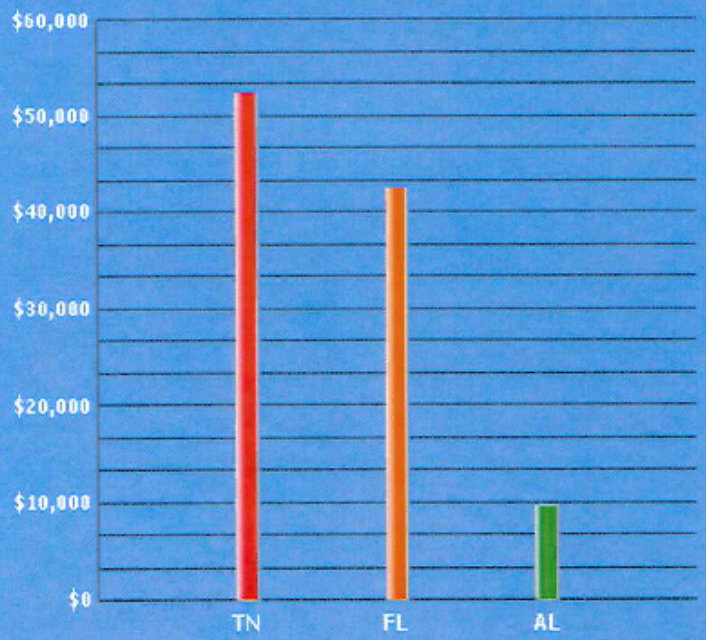
- Nursing
- Personal Care
- Residential Services

#1 Highest Expenditure on Nursing

Out of 3 states in CMS Region 4

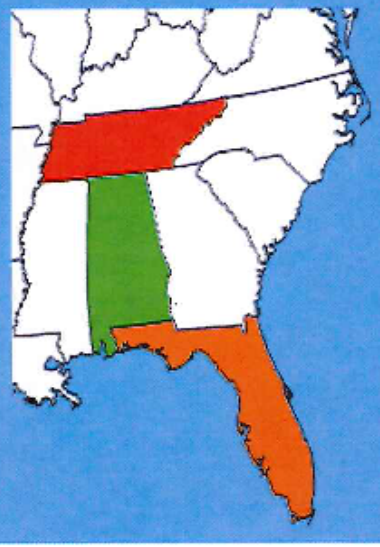
Per Person Expenditures on DIDD Services

Nursing



** "All Services" includes only service categories that are common to TN.

Tennessee's per person expenditure of $52,406.39 is 123% of the median value of $42,577.84 for states that offer this service.



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Waiting List

- 6,990 as of April 2014
- 5,655 are categorized as “active,” “urgent,” or “crisis”
- Remainder are “deferred”
- Does not include people with developmental disabilities other than intellectual disabilities

In addition to continuing to provide high quality services to people currently enrolled in HCBS programs that support choice, self-determination, independence and integration, **we *must* find ways to provide services as cost-effectively as possible in order to serve more people with intellectual and other developmental disabilities.**

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HCBS Waiver Renewal/Redesign

The Goal:

- Renew existing Arlington and Statewide 1915(c) waivers to ensure continuation of services for current waiver participants
- Make needed changes in the existing waivers
- Explore potential new program designs that would allow services to be provided more cost-effectively, allowing more people (including people with intellectual and developmental disabilities) to receive support

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HCBS Waiver Renewal/Redesign

The Process:

Gathering Stakeholder Input

- Commenced in December 2013
  - Meetings with advocacy and provider groups
- January-February 2014
  - Regional community meetings with consumers, family members and providers
  - Online survey tool
- February-March 2014
  - Written comments and other follow-up recommendations
- March 26, 2014
  - *Stakeholder Input Summary* issued; available at http://tn.gov/tenncare/forms/ID_DDStakeholderInputSummary.pdf

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HCBS Waiver Renewal/Redesign

The Process:

Input Focused On…

- The kinds of HCBS that people with intellectual and developmental disabilities need most
- The kinds of supports that family caregivers of people with intellectual and developmental disabilities need most
- Ways HCBS for people with intellectual and developmental disabilities can be improved
- Ways to provide HCBS to people with intellectual and developmental disabilities more cost effectively so that more people who need services and supports can receive them

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HCBS Waiver Renewal/Redesign

The Process:

What Stakeholders Said

- Smaller, capped waiver(s) serving more people
- Less restrictive (more independent) community living options (less than 24 hour care)
- Preventive ("support") services to avoid crisis
- Family education, navigation and supports
- Integrated, competitive employment and day service options
- Transition for young adults
- Coordination/integration of physical/behavioral health and HCBS
- More appropriate/effective behavior services
- Consistent, well trained, quality direct support staff
- Streamlined program requirements and processes

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HCBS Waiver Renewal/Redesign

Overarching Objectives:

- Continue to offer high quality services that support choice, self-determination and independence in the most integrated setting appropriate, with a strong focus on integrated, competitive employment and independent community living
- Deliver services more cost-effectively and in accordance with the individual's assessed needs
- **Realign incentives** and reallocate new and existing ID service funds to serve more people (including people with intellectual and other developmental disabilities)
- Improve coordination of physical and behavioral health and LTSS

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HCBS Waiver Renewal/Redesign

Opportunities:

- Align payment with value and outcomes
  - Employment
  - Independent living

- Explore potential assessment-based episodes of care
  - Self-directed options

- Enhanced care coordination support through health homes agency models targeted to individuals with I/DD

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HCBS Waiver Renewal/Redesign

Next Steps:

- Release concept paper by the end of the month
- Gather stakeholder input
  - Regional community meetings with consumers, family members and providers
  - Post online/accept written comments
- Review input and draft waiver amendments
- Post draft waiver renewal applications/amendments on TennCare and DIDD websites/accept written comments
- Review input and finalize and submit waiver amendments
- Continue working with stakeholders in program design and implementation

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Questions?

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